



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CROWN CHIROPRACTIC
2401 N ARKANSAS
LAREDO TX 78043

Respondent Name

ZURICH AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number: 19

MFDR Tracking Number

M4-12-2098-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated in the Rational for Reconsideration: "This patient was seen post DD exam. I believe the exam I performed should be compensable and paid for because of the following: (given to me by the Laredo Field Office, TDI/DWC) The DD opinion will be adopted unless an alternate certification is found to more correctly reflect a different date of MMI or a different IR. If there is a cost associated with this alternate certification/examination of the injured worker and the preparation of the Report of Medical Evaluation (DWC069) and a narrative [sic] report, it is my opinion that Rule 130.2 and Sections 415.002(a)(21) and 415.0035(a)(3) of the Worker's Compensation Act are authority for the proposition that the worker's compensation insurance carrier must pay that cost.."

Amount in Dispute: \$650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier, however, maintains that reimbursement is not owed for the May 31, 2011 services as they were neither medical treatment related to the compensable injury nor reasonable and necessary treatment for any condition. The evaluation was conducted purely as a litigation motivated action to develop evidence for the contest case hearing. Dr. Setliff's evaluation in no way 'cured or relieved the effects' of the injury, 'promoted recovery,' or 'enhanced the ability of the employee to return to work.'" See Texas Labor Code §401.011(31). Accordingly, the service was not a 'Medical Benefit' and defined by the Act, but merely a litigation expense not unlike an expert witness fee, to be borne by the party requesting that evidence. Carrier maintains that reimbursement is not owed for these services.

Response Submitted by:

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 3, 2011	CPT Code 99456-WP	\$650.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).
4. This request for medical fee dispute resolution was received by the Division on February 16, 2012
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
Explanation of benefits dated June 28, 2011:
 - 216 – Based on the findings of a review organization.
 - 854 Unnecessary Medical Treatment.

Issues

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution.
2. The requestor has failed to support that the services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____	_____	April 26, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.